Non-Emergency Hospital Diversion Program

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

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Non-Emergency Hospital Diversion Program

Introduction

In preparing this proposal over the past several months, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has followed-up on the work of the Special Senate Commission to Study Emergency Department Diversion, co-chaired by Senators Paul V. Jabour and Joshua Miller.

The Department staff met with many of the stakeholders involved with the Commission to further discuss their ideas and suggestions for this program. From numerous discussions with emergency department physicians and staff, clients who have utilized the emergency room for substance abuse care, DOH/EMS regulators and professionals, other state agencies, municipal public safety officials, substance abuse and mental health providers, housing organizations, homeless services and shelter providers, employment assistance specialists, researchers and officials who manage similar programs in other states, the Department has gained a realistic perspective of successful approaches to address this population of chronically intoxicated or drug-influenced individuals, who are currently treated in the hospital emergency rooms and then released to abuse substances again and again.

In fact, a program addressing this very issue existed in Providence in 1977, shortly after the laws were changed to eliminate public drunkenness as a crime. The Oxford Center at Talbot House was established to divert the chronic alcoholic-dependent population from the emergency rooms to an alternate facility and receive detoxification services and assistance with placement into long term treatment, temporary and permanent housing, and eventually, employment.

We have also reviewed the treatment history of the top chronic, alcohol-dependent individual utilizers of emergency room services and discovered that their alcohol abuse was frequently accompanied by mental illness, multi-substance abuse, chronic medical conditions and almost always, homelessness. Many of these individuals have been in multiple treatment programs, usually failing to complete treatment or suffering from relapse because of the lack of follow-up and housing/employment challenges. These are the key factors that will need to be addressed in this program for any measure of success to occur.

History

In Providence, and throughout the State, there has been a historic overreliance on municipal emergency transport vehicles and hospital emergency rooms as a source of treatment for individuals with non-emergency conditions and behavioral health issues. Current regulations require that emergency patients be transported by licensed ambulances staffed by licensed EMTs to a hospital, including those patients who happen to be intoxicated and collapsed in a public area. This practice is considered both wasteful and an inappropriate use of a high level of emergency transportation and medical care for non-emergency situations. This is currently occurring at a time when municipalities and hospitals have diminishing resources to appropriately serve the public.

In 2011, the Providence fire rescue conducted 32,604 emergency runs. Providence has one of the highest rates of emergency runs in the country, at 244 runs per 1,000 residents. It is estimated by the Providence Public Safety Commissioner that approximately 16,000 of those runs were considered non-emergency responses. The annual cost of operating Providence's six rescue units is $16 million. "In 2011, the Commissioner estimated that the City spent nearly $1.3 million of its fire rescue budget on transporting intoxicated or psychiatrically involved individuals to hospitals in Providence. Also that year, Rhode Island Hospital treated 160 people whose alcohol consumption landed them in the emergency room on 2,835 occasions….Eleven people made 1,109 of those 2,835 hospital visits, each of them doing so at least 50 times."[1]

With so many inappropriate non-emergency runs, the City is seeking ways to effectively address this issue to make available more emergency transport capacity for true emergencies without frequently calling other cities and towns for back-up, and to achieve savings for the City. In addition, hospital emergency rooms seek to reduce overcrowding from non-emergency cases, in part, by supporting a system whereby individuals who are suffering from severe intoxication could be managed at a more suitable location, where they could be encouraged to seek appropriate follow-up treatment and have better coordinated access to other community-based resources and supports.

In the 2012 legislative session, the General Assembly approved legislation[2] to make the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals responsible for presenting a proposal for a three-year pilot program to divert individuals impaired by substance abuse related issues to an alternative treatment program outside of the hospital emergency room. (The legislation is included in Appendix 1). The Department of Health will collaborate with the municipality involved to coordinate and develop transportation options for these individuals to the pilot program. Once approved by the Governor and the General Assembly, and funded with the required funds, this pilot program will begin to serve as a resource for emergency transport and hospital ERs to better serve this target population.

Recommendations of the Special Senate Commission

The Special Senate Commission to Study Emergency Department Diversion, co-chaired by Senators Paul V. Jabour and Joshua Miller, held several hearings and meetings from November 2011- January 2012 to study and discuss this issue. The following recommendations appear in pages 20-25 of the Findings and Recommendations Report submitted to the Rhode Island State Senate by the Special Senate Commission.

1. Amend existing RI alcohol statue to make it more flexible.
2. Create state-wide care partnerships to enhance patient-centered systems of care to include on-demand services, 24-hour triage center programs, mobile outreach transportation teams, and telephone triage system for substance use disorders/behavioral health issues.
3. Support opportunities through Health Homes Medicaid enhanced funding to include on-demand, substance use and/or behavioral healthcare and transitions to community supports.

[1] Reynolds, Mark; The Providence Journal; Sunday, July 22, 2012; page A11.
[2] Senate Bill 2561 Substitute A

4. Pilot program with evidence based suicide/mental health assessment tool and training for first responders, healthcare professionals to determine appropriate placement in ER or diversion program.[3]
5. Support the development of a pilot program with protocols for Emergency Medical Services (EMS) transports to alternative facilities. The Department of Health is ultimately responsible for this aspect of the program.
6. Support opportunities to enhance or reinvest savings for best practice housing models that include supportive services and employment/training linkages.
7. Support the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals in exploring opportunities for funding the alternative program.

RI General Laws

Certain statutes and regulations in RI that regulate emergency transport, hospital emergency rooms, treatment of alcoholics, mandated treatment, etc., will need to be reviewed and addressed relative to this program. Emergency room physicians who have traditionally treated these individuals will need to be oriented on the statutes to facilitate the use of the alternative treatment program and emergency commitments, as appropriate. The complete language of the cited statute sections appear in Appendix 1.

RI General Laws 23-1.10-10: Treatment and services of intoxicated persons and persons incapacitated by alcohol- requires that intoxicated persons be brought to an approved treatment facility for emergency treatment (affiliated with or part of the medical services of a hospital)… and shall be examined by a licensed physician as soon as possible. The facility planned for this pilot program would need to qualify as an approved treatment facility for persons to be transported to outside of a hospital emergency department, and staffed by qualified individuals other than exclusively licensed physicians, who can monitor the residents and help them move through the continuum of care towards recovery.

RIGL Chapter 23, Section 23-1.10-11, establishes a process for Emergency Commitment for intoxicated persons, which can be utilized for:.. "(1) an intoxicated person who has threatened, attempted, or inflicted physical harm on himself or herself or another and is likely to inflict physical harm on himself or herself or another unless committed, or (2) is incapacitated by alcohol"… As per the statute, a certifying physician, spouse, guardian, relative or any other responsible person can make a written application for commitment to the administrator of the approved facility for not more that ten (10) days. The Department, with the assistance of appropriate clinical providers, will develop the standards for consideration and review for these commitment requests. This existing statute, although potentially helpful for some of the current inebriant population, has not been used, primarily because there is no "approved public treatment facility for emergency treatment", as per the statute, that can provide a secured treatment environment. The proposed program would be designed to fulfill that status. The program would need to be able to secure those individuals who fall into the committed category and still have the flexibility to serve those who do not warrant mandated treatment.

[3] Potentially use the Columbia—Suicide Severity Rating Scale (C—SSRS)

RIGL Chapter 23, Section 23-1.10-12 establishes a process for longer term Involuntary Commitment of Alcoholics. This process, which involves a petition to the district court, can be utilized for those individuals who have the same risks of danger to themselves or others as described in the Emergency Commitment statute, along with the risk of continuing to suffer abnormal mental, emotional or physical distress, continuing to deteriorate in ability to function independently if not treated, and inability to make a rational and informed choice as to whether or not to submit to treatment. This commitment can continue for a stated period of time as the long as the likelihood of harm to him/her self or others continue to exist. The Department will evaluate the appropriateness of increased use of this statute after a period of evaluation of the experience of the program.

Proposed Program Model

In addition to attending and participating in all of the Senate Commission hearings and focusing on the Senate Commission recommendations, in preparing this proposal the Department reviewed the materials presented to the Commission, explored existing programs in other states, reached out to many of the stakeholder groups and community providers, as well as current and former consumers, to solicit input, clarify issues and suggestions. The Department also reviewed utilization and clinical profile data on afflicted individuals, and collaborated on planning the features of the program and roles of individuals and services. This proposed pilot program, suggested to be called the "Sobering Treatment Opportunity Program" or "***STOP***", will be initially developed to serve individuals in the City of Providence. Overseen by BHDDH and managed by the successful bidder, the *STOP* program will be a collaborative effort of the Fire and Police Departments of the City; RI Hospital and the Emergency Medicine physicians who staff the Emergency Department of the hospital; the Department of Health EMS Services; existing substance abuse and behavioral health providers who provide detoxification, treatment, care coordination and support services; homeless service providers who provide a range of transitional housing options for individuals struggling with substance abuse and in various stages of recovery; and the organizations who develop employment opportunities for recovering individuals.

Following are the key components of the proposal to address this issue. As per the statute,… "*subject to the approval from the governor and general assembly and the receipt of required funds, the director shall commence the implementation of the pilot program*"...and the Department will develop a Request For Proposal to solicit a vendor(s) for this pilot.

Transportation

Arrangements for transportation to the *STOP* program will need to be coordinated and developed with the municipality and the Department of Health. This can be accomplished by establishing and funding a community-based, homeless outreach response team. A transport van service can be created or outsourced, manned with an EMT and a homeless outreach worker. This service should be fully operative from early morning to late evening and, particularly during the stated peak hours of 10:00 AM- 2:00 PM, when EMS transport has frequently been called to transport this population to the hospital. The team will routinely travel to known areas where alcohol-dependant individuals spend time (i.e. the 300 block of Broad Street, Kennedy Plaza and

Chalkstone Avenue in Providence, etc.), homeless shelters as well as respond to calls reporting inebriated individuals in the City who need assistance.

The team will screen individuals for health issues other than alcohol or substance use and, if appropriate and permissible based on established clinical protocols, transport the individuals to the *STOP* program instead of jail or hospital ERs. As part of the screening, the team will utilize general criteria based on a pilot study of EMTs' field assessment of intoxicated patients' need for ED care[4]. The study indicated that the answer to all of these questions about the individual should be "No" to be considered appropriate for the Sobering Recovery Program alternative to the ED:

- Complaint other than alcohol intoxication?
- Age younger than 18 years?
- Abnormal vital signs (as defined in the protocols)?
- Abnormal pulse oximetry?
- Any sign of trauma?
- Any sign of illness?
- Any sign of environmental emergency?
- Abnormal blood sugar (as defined in the protocols)?
- Aggressive/confrontational?
- Other findings of concern?

As experience with the program and patients builds, some of the criteria may be modified based on the capacity of the program and treatment staff. As mentioned earlier, the statute which requires transportation of intoxicated persons to emergency treatment (…affiliated with or part of the medical services of a hospital… *RI General Laws 23-1.10),* would need to be modified.

In their travels, the *STOP* team will also work proactively to engage individuals to come to the Program before they are so inebriated that it would only be safe to take them to the ER. Police dispatch and local officers will have a direct line to the *STOP* outreach team, to facilitate a coordinated EMS transport to calls where intoxicated individuals may have medical, trauma or behavioral health issues likely requiring hospitalization.

Currently, private and public ambulance services are licensed through the Department of Health. The proposed vehicle for this pilot program will not be an ambulance, as it will not contain all of the ambulance equipment required for health emergencies and it will not have the minimum staffing required for an ambulance service. Therefore, this transport service, designed similar to those in programs in other states, will not require ambulance licensure.

[4] Cornwall AH, Zaller N, Warren O, et al. A pilot study of emergency medical technicians' field assessment of intoxicated patients' need for ED care. The American journal of emergency medicine. 2012;30(7):1224–8. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22056060

Sobering Treatment Opportunity Program (*STOP*)

Individuals who are caught in a cycle of inebriation and hospitalization need four critical supports to help them recover from this cycle and move towards leading productive and fulfilling lives:

- Medical stabilization and access to integrated healthcare services, including quick access to detoxification services and treatment services that are highly effective in engaging people who are often alienated from mainstream systems.
- Direct access to transitional housing which supports lifestyle change until they can access residential treatment and, eventually, permanent housing.
- The development of peer relationships that nurture and support personal transformation and recovery in a respectful environment.
- Attainment of income through employment or accessing benefits which will often require assisting clients to obtain "proofs" or legal documentation.[5]

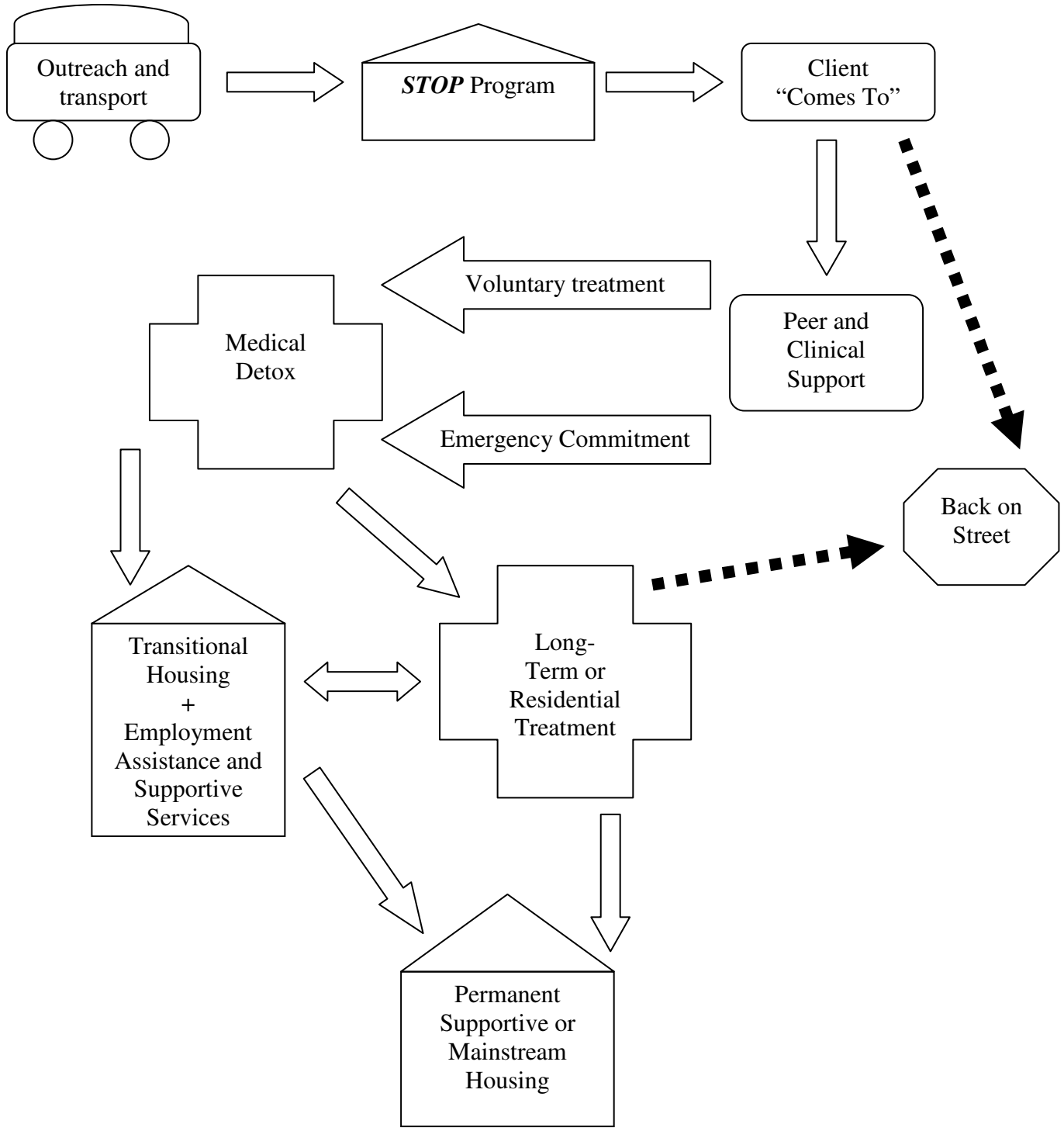
Additionally, programmatic and treatment values should be established as the foundation of the STOP. Safety of the clients and staff should be a priority. Clients should be treated with respect and dignity and not encounter the social stigma that occurs with these conditions. Prevention and early intervention should be utilized as often as possible. Treatment settings should be the right services at the right time in the most cost effective and accountable manner, leading to positive outcomes. Harm reduction and motivational counseling should be utilized to encourage clients to agree to participate and continue in treatment and recovery services. Care coordination and transition assistance should be provided throughout the client's involvement in the program.

Although voluntary engagement into the treatment and recovery program is always the preferred method, most clinicians and many clients consulted as part of this program have indicated that mandatory treatment is the best way to reach certain clients who have not been sober for a lengthy period of time. Due to excessive alcohol use and dependence, these individuals may have incurred a serious impact on brain functioning and the associated behaviors related to brain impairment. The argument is that these clients would need to maintain sobriety for a significant period of time to be able to understand what it would be like to be sober and to regain better brain, behavioral and physical functioning. To that end, mandatory treatment would be warranted. This would be appropriate for individuals who are deemed to be a danger to themselves or others because of their potential of becoming inebriated again and dying from alcohol poisoning, hypothermia, head or other trauma from falling or accidents, or from getting behind the wheel of a car. Typically, these clients may be out of immediate danger when they achieve reduced inebriation, but if they are released to continuously engage in the same addictive behavior, they are once again a danger to themselves and society. Therefore, there is a rationale for the option to mandate treatment.

[5] Food stamps, SSI, SSDI and Medicaid/Medicare require clients to have proof of RI residence, original birth certificate, photo ID, and a social security card.

Below is a flow chart of how the client will enter and move through the proposed pilot.

Flow Chart



Physical Space

In 1977, the City of Providence developed the Oxford Center at Talbot House as an alternative treatment program for intoxicated individuals being brought to hospital emergency rooms. The law de-criminalizing public drunkenness had just been passed and the program was responding to the increased use of hospitalization of these individuals versus arrest and detainment. The program included a 20 bed detoxification facility adjoined to an 80 bed temporary housing facility. In discussions with the former director of the program, it was learned that it was important to have multiple tiers of interaction/treatment (preferably co-located or in close proximity to each other) to continue engagement of the client, including arrangements for housing. It was also reported that mandatory treatment would have been very appropriate for many individuals who were repeat attendees and who continually left treatment before completion. The Oxford program ran successfully for 12-15 years before insurmountable capital costs of maintaining the facility and inadequate program funding caused the program to close.

The new *STOP* program will need to have adequate physical space where individuals can safely go to achieve short-term sobriety or safe reduction in inebriation and be engaged by peers and substance abuse treatment providers. It will need to be operational 24/7 and have the capacity in house or connections to medical detoxification for those that need it and are willing to participate. The co-location of services could lead to substantial cost savings.

Full time security will be needed to ensure the safety of clients and staff. It would be helpful to have a kitchen where food can be prepared and fluids can be stored to help clients regain sobriety.

There are several issues related to the location of the space. Locating it in direct proximity to the areas where these individuals are usually picked up may be convenient, but it may also decrease the likelihood of individuals becoming engaged because they will be so close to where they are tempted to get into trouble. However, locating it someplace that is not in the immediate problem environment, although less convenient, could be helpful to engage individuals in extended treatment, because it could be viewed as a place of healing and recovery that is separate and apart from the place so closely connected to alcohol use and inebriation. This has been the experience of the detoxification centers located outside of the City. Once again, if the location is or has the capacity to have locked units for mandatory treatment, the location may not be as much of an issue.

The physical space for *STOP* must include a safe space for individuals to sleep, shower, eat and meet privately with staff. Ideally, the *STOP* program and the transitional housing/recovery program will be co-located. The detoxification services could also be co-located, but there may be better economies of scale to increase capacity at existing detoxification programs.

The physical space for the combined short-term recovery program, detoxification services/or referral arrangements, and a transitional housing recovery program should have one area with bedrooms, showers and bathrooms, for a capacity of 15-20 individuals for short-term stays (24-

48 hours). It should have a separate area for congregate and private meeting rooms for group and private engagements with care coordinators, peers and treatment providers and to encourage provision of detoxification services. This area can also be used by professionals who could help clients with substance abuse treatment, relapse prevention, coping skills, employment, housing, benefits, education, exercise, family re-integration and general skill building during the day. By making this type of environment available to other homeless individuals, or those at risk of homelessness who have employment, training and educational needs, blended funding and collaboration could be promoted with the Office of Housing and Community Development and community-based providers of these services.

Since housing is such a critical factor in maintaining treatment gains and assisting in recovery, a second separate area with a capacity for 15-20 individuals, should be created to provide transitional housing to individuals who have "graduated" into sobriety. After which, other housing options, such as permanent, supportive, subsidized or mainstream housing can be arranged. This is also important for engaging individuals to pursue treatment, because the existing transitional housing capacity is not sufficient for immediate placement. Most residential treatment programs require 30 days of sobriety before admission, which this component of the Program can provide. By co-locating these services, financial efficiencies for staffing and space can be maximized and an individual needs-based, responsive system of care can be provided. If the space is large enough to accommodate a health clinic, further safety and wellness could be facilitated with clients. Finally, the utilization of an existing publicly owned property may be more financially viable than purchasing/leasing private property.

Medical Stabilization

Providing detoxification services in the *STOP* program will allow for true engagement with the client. Otherwise, clients without this option typically disengage within 24 to 48 hours when comfort levels and danger of seizures and other serious physical problems are exacerbated without the ingestion of alcohol. Currently, BHDDH-funded detoxification slots average about a 7-10 person wait list, which means that quick access to existing State funded resources, is not available. Current wait time can be anywhere from hours to days, depending on the volume and availability of funded slots. Detoxification capacity will need to be increased to adequately serve the population in this new initiative.

Developing a new detoxification program has ethical and legal liability challenges. Individuals with serious medical conditions requiring medications and access to hospital-level medical devices are not appropriate for non-hospital based detoxification services. Admitting an individual who cannot verbalize what they have taken (alcohol and/or other drugs) and how much, is also a concern. Assessment and medical clearance, as per clinical protocols, should be performed prior to engagement of the client to assure that the client is in the proper treatment setting.

In a detoxification service, a second level triage and assessment is provided to assure that the client is appropriate for the Program. Vital signs with pulse oxymetry will be taken, along with a BAL (Breathalyzer) every 20-30 minutes upon admission. A history and physical exam administered by the RN team member, and a standardized assessment tool, should be used as

well as a simple blood glucose test to determine if other issues are contributing to the client's condition. Screening to identify potential mental health issues should also be performed including use of an evidence based suicide/mental health assessment tool, where appropriate.

When the detoxification starts, often benzodiazepines are necessary to avoid blood pressure problems leading to heart attacks and/or seizures. A licensed clinician at the program would need to take responsibility for the proper evaluation of clients' medication history and monitoring the client's condition. A system should be established to assess (score) the level of detoxification on an ongoing basis to facilitate effective communication among staff as the client recovers. Continuous care of the client will involve monitoring vital signs, addressing nutrition/clothing/comfort needs, monitoring alcohol withdrawal and administering appropriate medications (as per protocols).

It is recommended that the ED Physician's group at RI Hospital and medical interns and residents from Brown University Medical School be available to provide medical support and staff for daily rounds and ongoing coordination at the facility to monitor medical issues, prescribe medications, perform minor primary care services, and facilitate transfer to the hospital, whenever necessary.

As communicated to the Department by the ED Physicians Group, presence of any of the following signs or symptoms of the impaired individual will be grounds for immediate transport to the hospital ED:

- Complaints in addition to alcohol intoxication
    - Head Trauma
    - Significant other trauma
    - Chest pain
    - Acute abdominal pain (does not include chronic daily abdominal pain)
    - Hematemasis (bloody vomit)
    - Suicidality or Homocidality
    - Belligerent or threatening behavior
- Abnormal vital signs
    - Systolic blood pressure >180 or <90
    - Pulse >115 or <50
    - Oxygen saturation <92%
    - Temperature >99.9 F or < 97.0 F
    - Blood glucose <75mg/dL(if able to dink juice) or <80 mg/dL if unable to drink juice or >200 (without a history of diabetes) or >300 (with a history of diabetes)
- Abnormal physical exam findings
    - New trauma to the head or face
    - Cervical spine midline tenderness
    - Laceration requiring suture closure
    - Significant abdominal tenderness to palpation
    - GCS <13 (This will exclude patients with excessive somnolence)
    - Focal neurologic findings (i.e. new weakness)
    - CIWA (alcohol withdrawal score) >10 [2]

ED doctors receiving clients with serious medical issues in addition to inebriation should determine if the clients have or are at risk for Wernicke-Korsakoff syndrome, Korsakoff's psychosis, Wernicke's encephalopathy, or beri beri which would require a more acute, longer term referral to care. In these cases, the use of mandated treatment may be indicated.

Community-Based Services and Supports

For individuals without serious medical conditions that require a hospital setting, community-based detoxification with affiliated services would be appropriate. Peer specialists should be utilized to help engage clients and guide them through the steps of participation, recovery and ongoing support services in the program. Preferably, the site used for the *STOP* program will have, or be connected to, a diverse set of day program opportunities that serve as an alternative to consuming alcohol, and help break the daily cycle of chronic inebriation and required acute recovery services. Blending funding and sharing space with homeless service providers seeking to provide day programs, intake, assessment and referrals for their clientele to community based services, would also create service coordination and financial efficiencies.

Housing, employment and ongoing support benefits are the critical components of achieving and maintaining sobriety and fostering meaningful recovery. Types of services available in the community that would be helpful to this population include, but are not limited to, the following:

Housing:
- Housing location programs
- Housing First and other community-based housing programs
- Section 8, Rhode Home, Shelter Plus Care
- Rental classes and other educational programs on successful housing retention
- Veteran's Housing Assistance programs
- Veteran's community outreach and housing programs
- Public Housing Authorities

Employment:
- State employment support agencies and programs like ORS, Ticket to Work and DLT
- Community-based training and employment programs
- Community-based placement programs
- Integration with Governor's plans to increase employment in the State

Benefits:
- SSI/SSDI Outreach, Access and Recovery (SOAR)
- Benefits Specialists (from CMHOs)
- Veteran's Benefits Administration
- The Point/Options Counseling and other programs through Medicaid/Medicare

It is important that clients feel cared for and engaged in their care. However, the question of enabling unhealthy behavior is also a concern. A number of these clients have regularly refused ongoing treatment and support. Voluntary engagement in treatment is always preferred, therefore, policies must be developed to create incentives to get individuals to make use of the

service opportunities that are available through the *STOP* program. Some examples of incentivizing policies would be to require individuals, who go the program three or four times in a four-day period, to sign a pledge to participate in treatment and support the next time they need help. Vouchers for food, clothing, housing, etc., have also been effective. The Courts have a history of recommending treatment for individuals involved in the criminal justice system as a part of their judgments. While these clients are typically involved in misdemeanor level infractions that call them to the attention of the police (public nuisance, disorderly conduct, etc.), there is still a precedent for recommending treatment as part of one's plea. As discussed earlier, the Department has received consistent recommendations to include a mandatory treatment capability as an option, as appropriate and necessary.

With expanded Medicaid eligibility under the Affordable Care Act, the landscape for supportive housing programs is changing as a majority of homeless persons will become eligible for Medical Assistance. Supportive Housing is affordable housing coupled with supportive services that focus on housing retention. It is a cost effective intervention that has been shown to reduce use of emergency systems and provide better outcomes for the individuals housed. Housing is the intervention and without this stabilizing mechanism many individuals continue to cycle through expensive emergency treatment and other service systems.

Since most of the frequent, chronically alcohol-dependent individual utilizers of the emergency department services are homeless, in order to reap the benefits of the services described in this report, housing must be part of the equation. It is recommended that operating subsidies and rental vouchers be created for this population, enabling affordable housing projects and market rate landlords to assist lower income individuals (including the homeless and disabled).

The State's approved affordable housing bond (along with other programs) will be capable of providing capital funding to affordable housing projects, which need to produce annual income sufficient to cover management costs. Households contribute 30% of their income towards housing costs but, with very low income populations, such as the population targeted in this initiative, this amount is not sufficient to cover operating costs for a unit. Therefore, without any additional subsidy, projects must target higher income populations. In order to assure projects target lower income families/households the provision of an operating gap subsidy is necessary. This Operating Initiative would provide for the difference between what a very-low income household is able to pay and what is needed to maintain a unit. Funds would be targeted specially to households experiencing homelessness.

The housing representatives recommend that the State create a flexible fund that could also be used to create rental vouchers. This would allow households a choice; with rental vouchers households pay 30% of income for rent and units can be leased in the open rental market.

BHDDH has worked closely with the Office of Housing and Community Development and supports its request in the amount of $3 million for an operating/ rental subsidy pilot.

It will be essential to have a program evaluation component for the STOP program to assess implementation success and outcomes. The Department is required to report annually on its findings and recommendations and, after three years of operating the pilot, to provide an analysis demonstrating outcomes related to the pilot program. It will be necessary to develop a more responsive data gathering and reporting system to supplement the Behavioral Health On-line Data "BHOLD" system the Department utilizes to track encounters.

The program evaluation component will also be helpful in identifying overall potential health care savings that would be achieved by reducing emergency room visits, hospital admissions, and other health care costs incurred by inadequate or non-coordinated care, and the lack of maintaining treatment gains with support services. These potential savings could be available to offset cost of the *STOP* program.

Recommendation

The Department recommends that the Administration and General Assembly review this proposal and, working with BHDDH, determine the desired size and scope of the *STOP* program, and whether or not a State facility will be made available for the program. Once these decisions are made, the Department will prepare a budget more reflective of the program costs. The General Assembly will then be asked to provide adequate and dedicated funding for a Request for Proposal to be released to vendors, to develop and provide the services related to the *STOP* program.

Estimated Budget

An important part of the budget for this program will be funding for expansion of detoxification services, transitional housing, support services and employment assistance. These essential components will facilitate ongoing treatment and recovery, and provide alternatives to the cycle of intoxication and inappropriate hospital utilization once the initial intervention occurs. This is a rough general estimate based on existing and proposed programs that address this issue.

Client Transportation

Required funding: Funding will be dependant on what the vehicle and staffing pattern look like. There have been programs run by non-medical professionals that provide outreach to homeless individuals in the community. There may even be vehicles that are appropriate or can be retrofitted that are currently in use by existing programs during off-peak hours for the typical rescue calls for alcohol-dependent individuals calls (approximately 9:00 AM to 4:00 PM).

This 3-year estimate includes the purchase, maintenance, insurance, repair and upkeep of one vehicle (experience will indicate the need for additional vehicles). This estimate also includes staffing of the vehicle with an outreach worker and EMT level medical provider plus project oversight and agency overhead. See spreadsheets for detailed breakdown in Appendix 3.

	Annual Cost	3-Year Pilot Cost
Staffing	$193,750	$581,250
Vehicle purchase and upkeep	$23,052	$69,155
Admin: 10%	$21,680	$65,040
TOTAL	**$238,482**	**$715,445**

STOP Program Services

Required funding: Funding will provide staffing for **c**linical, peer support, administrative, maintenance, kitchen and security services, which will create a safe environment for alcohol dependent individuals to achieve a reasonable reduction in inebriation, enabling them to be able to make choices about their engagement in medical detoxification services or refusal to do so. The staffing for this includes clinical (RNs, case managers, and residential assistants), security, and administrative staff. The operational costs for the facility includes rent, utilities, property tax, building repair and maintenance, cleaning, snow removal and landscaping (note: rent and taxes could be eliminated if state property is used but it might require additional costs in year one for renovations). Operational costs for the program include payroll processing, legal, auditing, professional/general liability insurance, etc. An additional cost estimate for food and client activities is included.

	Annual Cost	3-Year Pilot Cost
Staffing Physician coverage**(?)**	$998,071	$2,994,213

Operations for facility	$113,500	$340,500
Operations for program	$45,567	$136,,701
Food and client activities	$27,600	$82,800
Admin: 10%	$118,474	$355,422
TOTAL	**$1,303,212**	**$3,909,636**

Detoxification Services

Range of required funding: Funding will be dependant on the number of additional slots made available and if programs capable of providing detoxification can be expanded, or if a new program with a new facility needs to be developed.

	Annual Cost	**3-Year Pilot Cost**
Medical Detoxification:		
8 additional beds @ $175/bed day @ 365 days/year	$511,000	$1,533,000
TOTAL	$511,000	$1,533,000

Transitional Housing

Range of required funding: This will depend on where the initial transitional housing is located. If the proposed 20 bed capacity facility is co-located with the *STOP* facility there could be economies of scale in terms of staffing. If the location were state-owned property the cost of purchase would be eliminated, but renovations would be required in the first year. In addition, ongoing upkeep and operating costs would be required on an annual basis. Other programs in the State have used a variety of vouchers and other funding sources to pay for the ongoing costs. Examples of these costs for other programs and proposed programs follow.

NOTE: there is no total for the program listed in this table as the prices range depending on the property and program structure (state-owned versus purchased, level of renovations required, co-location of services for STOP program and transitional housing recovery program, and overall space for other community providers of homeless services).

Project Component	**Initial or annual coast**
Property Purchase:	$300K - $1.5 M
Property Rehabilitation:	$300K - $600K
Operational Costs, State-Owned Property:	$43,000
Maintenance: (building, furniture, appliances, equipment and grounds), Heat, Water, Electric, Sewer, Food	
Additional Operational Costs, Non-State-Owned Property:	$85,000
Taxes, Lease or rent	
Program Costs	
Staffing: Clinical, peer support, administrative, security	$100K - $300K

Bridge Housing (Limited Time Rental Vouchers)

Range of required funding: This would be a way to help people succeed in a supportive housing model following residential treatment. In order to make sure units are available and this program is accessible for future clients, the funding should be for two years with potential for a one-year extension based on an evaluation of clients' success in the program. This is the amount of time it typically takes to get into regular subsidized housing. The issue that has arisen in the past is that clients who receive an unlimited time voucher typically keep the voucher long-term, or for life, so that they do not move into mainstream housing, thus freeing up the vouchers for others.

This model is currently being advocated for by the Office of Housing and Community Development (OHCD). It is a model that would be appropriate for all chronic homeless, not just alcohol dependent individuals. Therefore, this would be an opportunity to collaborate and potentially blend funding for a program that serves the missions of BHDDH and OHCD.

Employment and Training

Range of required funding: In order to properly assess the costs of this service, the STOP program will work with the Department's Employment First Initiative and other employment assistance programs within the state.

Program Evaluation

Range of required funding: Traditionally, evaluation is approximately 20-25% of total program costs. Some of this expense can be deferred by using outcomes measured in the existing BHDDH BHOLD system. However, new data agreements need to be formulated with participating partners to track the success of referrals to community partners, and other data as deemed appropriate by the Department

Appendix 1: RI General Laws

§ 23-1.10-9 Voluntary treatment of alcoholics. – (a) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he or she, a parent, a legal guardian, or other legal representative may make the application.

(b) Subject to rules adopted by the director, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment; provided, however, that a person so admitted may be held by the department for at least thirty (30) days. That person shall be released at the end of thirty (30) days upon written request to the administrator in charge of the treatment facility. If a person is refused admission to an approved public treatment facility, the administrator, subject to rules adopted by the director, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(c) If a patient receiving inpatient care leaves an approved public treatment facility, he or she shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the department shall arrange for assistance in obtaining supportive services and residential facilities.

(d) If a patient leaves an approved public treatment facility, with or against the advice of the administrator in charge of the facility, the department will attempt to make reasonable provisions for his or her transportation to another facility or to his or her home. If he or she has no home, he or she shall be referred or advised to make contact with the appropriate state or federal agency for assistance in obtaining shelter. If he or she is a minor or an incompetent person, the request for discharge from an inpatient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he or she was the original applicant.

§ 23-1.10-10 Treatment and services for intoxicated persons and persons incapacitated by alcohol. – (a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he or she consents to the proffered help, may be assisted to his or her home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police.

(b) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police and immediately brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available, he or she shall be taken to an emergency medical service customarily used for incapacitated persons. The police, in detaining the person and in taking him or her to an approved public treatment facility, are taking him or her into protective custody and shall make every reasonable effort to protect his or her health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself or herself. If it is impracticable to take a person to an approved facility, the police may take him or her into protective custody in the police station in suitable quarters, for a reasonable time. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

(c) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He or she may then be admitted as a patient or referred to another health facility, or be released to his or her own custody. The referring approved public treatment facility shall arrange for his or her transportation as provided for in § 23-1.10-9(d).

(d) A person who by medical examination is found to be incapacitated by alcohol at the time of his or her admission or to have become incapacitated at any time after his or her admission, may not be detained at the facility: (1) once he or she is no longer incapacitated by alcohol, or (2) if he or she remains incapacitated by alcohol for more than five (5) days after admission as a patient, unless he or she is committed under § 23-1.10-11. A person may consent to remain in the facility for as long as the physician in charge believes appropriate.

(e) A person who is not admitted to an approved public treatment facility, who is not referred to another health facility, and who has no funds may be taken to his or her home, if any. If he or she has no home, the approved public treatment facility shall refer or advise him or her to make contact with the appropriate state or federal agency for assistance in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, his or her family or next-of-kin shall be notified as promptly as possible if requested by the patient. If an adult patient who is not incapacitated requests that there be no notification, his or her request shall be respected.

(g) The police, who act in compliance with this section, are acting in the course of their official duty and are not criminally or civilly liable for acting in the course of their official duty.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

§23-1.10-11: Emergency commitment - (a) An intoxicated person who (1) has threatened, attempted, or inflicted physical harm on himself or herself or another and is likely to inflict physical harm on himself or herself or another unless committed, or (2) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he or she has examined the person sought to be committed within two (2) days before the certificate's date and facts supporting the need for emergency treatment.

(c) Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he or she was admitted, or

transferred to another appropriate public or private treatment facility, until discharged under subsection (e).

(d) The administrator in charge of an approved public treatment facility shall refuse an application if in his or her opinion the application and certificate failed to sustain the grounds for commitment.

(e) When, on the advice of the medical staff, the administrator determines that the grounds for commitment no longer exist, he or she shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than ten (10) days. If a petition for involuntary commitment under Â§ 23-1.10-12 has been filed within the ten (10) days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he or she may detain the person until the petition has been heard and determined, but no longer than ten (10) days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within twenty-four (24) hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult counsel.

RI General Laws §23-1.10-12: Involuntary commitment of alcoholics - (a) A person may be committed to the custody of the department by the district court upon the petition of his or her spouse or guardian, a relative, the certifying physician, or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he or she: (1) has threatened, attempted, or inflicted physical harm on himself or herself or another and that unless committed is likely to inflict physical harm on himself or herself or another; or (2) will continue to suffer abnormal mental, emotional, or physical distress, will continue to deteriorate in ability to function independently if not treated, and is unable to make a rational and informed choice as to whether or not to submit to treatment, and as a result, poses a danger to himself or herself. Evidence that the person has had numerous short-term, involuntary admissions to a treatment facility shall be considered by the court in making a decision pursuant to this chapter. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within three (3) days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition.

(b) Upon filing the petition, the court shall fix a date for a hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his or her next-of-kin other than the petitioner, a parent or his or her legal guardian if he or she is a minor, the administrator in charge of the approved public treatment facility to which he or she has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(c) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present unless the court believes that his or her presence is likely to be injurious to him or her; in this event the court shall appoint a guardian ad litem to represent him or her throughout the proceeding. The court shall examine the person in open court, or if advisable shall examine the person out of court. If the person has refused to be examined by a licensed physician, he or she shall be given an opportunity to be examined by a court-appointed licensed physician. If he or she refuses and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him or her to the division for a period of not more than five (5) days for purposes of a diagnostic examination.

(d) If after hearing all relevant evidence, including the results of any diagnostic examination by the department, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the department. It may not order commitment of a person unless it determines that the department is able to provide adequate and appropriate treatment for him or her and the treatment is likely to be beneficial.

(e) A person committed under this section shall remain in the custody of the department for treatment for a period of thirty (30) days unless sooner discharged. At the end of the thirty (30) day period, he or she shall be discharged automatically unless the department before the expiration of the period obtains a court order for his or her recommitment upon the grounds set forth in subsection (a) for a further period of ninety (90) days unless sooner discharged. If a person has been committed because he or she is an alcoholic likely to inflict physical harm on himself or herself or another, the department shall apply for recommitment if after examination it is determined that the likelihood still exists.

(f) A person recommitted under subsection (a) who has not been discharged by the department before the end of the ninety (90) day period shall be discharged at the expiration of that period unless the department, before the expiration of the period, obtains a court order on the grounds set forth in subsection (a) for recommitment for a further period not to exceed ninety (90) days. If a person has been committed because he or she is an alcoholic likely to inflict physical harm on himself or herself or another, the department shall apply for recommitment if after examination it is determined that the likelihood still exists. Only two (2) recommitment orders under subsection (e) and (f) shall be permitted.

(g) Upon the filing of a petition for recommitment under subsection (e) or (f), the court shall fix a date for a hearing no later than ten (10) days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his or her next-of-kin other than the petitioner, the original petitioner under subsection (a) if different from the petitioner for recommitment, one of his or her parents or his or her legal guardian if he or she is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (c).

(h) The department shall provide for adequate and appropriate treatment of a person committed to its custody. The department may transfer any person committed to its custody from one approved public treatment facility to another if transfer is medically advisable.

(i) A person committed to the custody of the department for treatment shall be discharged at any time before the end of the period for which he or she has been committed if either of the following conditions is met:

(1) In case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon himself or herself or another, that he or she is no longer an alcoholic or the likelihood no longer exists; or

(2) In case of an alcoholic committed on the grounds of the need of treatment, deterioration, inability to function, or the fact that he or she is a danger to himself or herself, that the deterioration no longer exists, that he or she is no longer a danger to himself or herself, that he or she is able to function, that further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(j) The court shall inform the person whose commitment or recommitment is sought of his or her right to contest the application, be represented by counsel at every stage of any proceedings relating to his or her commitment and recommitment, and have counsel appointed by the court or provided by the court if he or she wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him or her regardless of his or her wishes. The person whose commitment or recommitment is sought shall be informed of his or her right to be examined by a licensed physician of his or her choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

2012 -- S 2561 Substitute A- An Act relating to health and safety- alcoholism
SECTION 1. Chapter 23-1.10 of the General Laws entitled "Alcoholism" is hereby amended by adding thereto the following section:

23-1.10-20. Pilot alternative program established. – (a) There is hereby created a program for individuals impaired by substance abuse related issues, as an alternative treatment/referral service to the emergency room department, to foster their entry into a continuum of care for treatment and recovery. This pilot program shall be an addition and shall not alter the comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons as set forth in section 23-1.10-6.
(b) As used in this section, the following words and terms shall have the following meanings:
(1) “Department” means the Rhode Island department of behavioral healthcare, developmental disabilities and hospitals.
(2) “Pilot program" means the program described in this section. The pilot program shall not be subject to subsections 23-1.10-10(a), (b), (c) and (d).
(3) “Substance abuse related issues” means any of the symptoms that are caused by either active substance use, substance abuse/dependence or a combination of both.
(c) No later than December 31, 2012, and subject to approval of the Rhode Island

executive office of health and human services, the department shall present a proposal to the governor and general assembly to expand existing service(s), that shall result in services described in subsection (a) available twenty-four (24) hours a day, seven (7) days a week to implement the pilot program.

(d) Subject to approval from the governor and general assembly and the receipt of required funds, the director shall commence the implementation of the pilot program.

(e) The director may adopt such rules and regulations governing the management of the pilot program as he/she deems necessary to carry out the provisions of this section.

(f) The pilot program shall have a duration of three (3) years, commencing on the date that the first licensed facility becomes operational.

(g) The department shall provide an annual report of its findings and recommendations to the general assembly and governor no later than January 31st of each year beginning in 2014.

(h) After three (3) years of operations, the department shall provide an analysis demonstrating outcomes related to the pilot program to the general assembly and governor.

SECTION 2. Transportation options shall be coordinated and developed by a local city/or town, in conjunction with the department of health, prior to the pilot program implementation. Funding for alternative transportation is not part of the pilot program.

SECTION 3. This act shall take effect upon passage.

Appendix 2: Essential Services to Retain Individuals in Supportive Housing

Categories of Community-based Support Services:

These services are individualized based on client needs and include health care coordination (including mental health and substance use), assistance navigating social service and benefit systems, and housing maintenance support. The list that follows details these services:

- Care Management or Service Coordination
  - *Assessment*
    - Services intake
    - Assessment-identifying client need
    - Gathering required documents for eligibility determination
    - Arranging for further testing and evaluation
    - Conducting reassessments
    - Documenting assessment activities
  - *Service Plan Development:*
    - Service plan development with client/tenant
    - Writing service plan
    - Determining who should provide services
    - Obtaining signatures
    - Update and review service plan
    - Documenting service plan development
  - *Referral, Monitoring, Follow-up:*
    - Referrals to other ancillary services
    - Referral and related activities
    - Assist in connecting to services
    - Coordination of services identified in service plan
    - Monitoring and evaluation
    - Documenting referral, monitoring and follow-up
    - Personal advocacy
- Medication management/monitoring
  - Harm reduction strategies
  - Substance abuse counseling
  - Peer counseling, mentoring
  - Education about mental illness
  - Psychotropic medication education
  - Recovery readiness
  - Relapse prevention
- Routine medical care, medication management, vision, dental, HIV/AIDS services
  - Medication set-up
  - Medication coordination
  - HIV/AIDS/STD education
  - End of life planning
- Entitlement assistance/benefits counseling
  - Entitlement and benefits counseling

    - Application for income assistance and the Supplemental Nutrition Assistance Program
    - Application for health benefits, including Medical Assistance and specific programs funded through Medical Assistance
    - Referral to legal advocacy and assistance with appeals, when needed, to appeal a denial of public benefits
    - Budgeting and financial education
- Transportation
    - Transportation - non-medical
    - Care manager accompaniment on appointments
- New tenant orientation/move-in assistance
    - Finding housing
    - Applying for housing
    - Landlord advocacy
    - Securing household supplies, furniture
    - Tenancy supports
    - Eviction prevention
- Outreach and in-reach services
    - Identifying and engaging with un-served, under-served and poorly-served individuals
    - Connecting individuals with mainstream services
- Independent living skills training
    - Nutrition education
    - Cooking/meal prep
    - Personal hygiene and self-care
    - Housekeeping
    - Apartment safety
    - Using public transportation
- Job Skills training/education
    - School connections
    - Access to social support
    - Truancy intervention
    - Access to academic support
    - Opportunities/access to GED, post-secondary school training
    - Supported employment
    - Childcare connection to resources)
- Domestic Violence intervention
    - Domestic abuse services
    - Crisis planning, intervention
    - Child protection assessment, follow-up
    - Referral to legal advocacy
    - Training in personal and household safety
    - Crisis intervention-clinic based or mobile crisis
- Support groups self-determination/life satisfaction
    - Grief counseling
    - Development of recovery plans

    - Group therapy
    - Recreation
    - Social support
    - Community involvement/integration
    - Parenting supports and mentoring
    - Peer monitoring/support
    - Conflict resolution/mediation training
- Respite care
- Individual counseling
- Discharge planning
- Reengagement

Appendix 3: Budget Assumption Detail

Transportation Program

				Cost			
				Year 1	Year 2	Year 3	Total
Vehicle				$50,000			$50,000
Maintenance				$1,000	$1,000	$1,000	$3,000
Insurance				$1,000	$1,500	$1,500	$4,000
Fuel	7300	miles	0.555	$4,052	$4,052	$4,052	$12,155
Vehicle Total				$56,052	$6,552	$6,552	$69,155

				Cost			
Staff Title	#	%FTE	Salary+Fringe	Year 1	Year 2	Year 3	Total
EMT	1.5	100%	$75,000	$112,500	$112,500	$112,500	$337,500
Outreach worker	1.5	100%	$50,000	$75,000	$75,000	$75,000	$225,000
Program Manager	1	5%	$125,000	$6,250	$6,250	$6,250	$18,750
Staff Total						$193,750	$581,250

Staff Total	$193,750	$581,250
Vehicle Total	$23,052	$69,155
Overhead	$21,680	$65,040
PROGRAM TOTAL	$238,482	$715,445

Emergency Room Diversion Project Draft Budget

Part 1

Staffing:	FTE		Salary	Fringe	
Manager	1.0	50,000	50,000	12,500	62,500
RN	3.0	65,000	195,000	48,750	243,750
RN per-diem	2.0	69,000	136,432	13,643	150,075
Security	3.0	31,000	93,000	23,250	116,250
Security per diems	2.0	25,875	51,162	5,116	56,278
Residential Assistant	3.0	33,000	99,000	24,750	123,750
Residential Assistant per diems	2.0	25,875	51,162	5,116	56,278
Case Manager	2.0	36,000	72,000	18,000	90,000
Case Manager per diem	0.5	31,050	15,172	1,517	16,689
NP	0.6	110,000	66,000	16,500	82,500
Subtotal Staffing					998,071
Rent					48,000
Utilities					25,000
Property tax					25,000
Building R&M					6,000
Cleaning					5,000
Snow removal					2,500
Landscaping					2,000
Subtotal Occupancy					113,500
Food	10	$4	perday		14,600
Client activities					3,000
Residential Supplies					5,000
Phone					3,000
Travel					2,000
Subtotal client expense					27,600
Allocated operating expense (payroll processing, legal, auditing, professional/general liability insurance, etc.)	4%				45,567
Total direct expense					**1,184,737**
Allocated Admin	10%				118,474
Total cost					**1,303,211**
Cost per bed day:					
# beds	**15**				
Assuming	**80%**	**occupancy, cost per bed day**			**$298**

Staffing details

Per diem calculations:

RN

shifts/day	3
shifts/wk	21
days/yr	365
shifts/yr	1095
shifts by staff	660
per diem shifts	435
per diem FTE	1.98

Security

shifts/day	3
shifts/wk	21
days/yr	365
shifts/yr	1095
shifts by staff	660
per diem shifts	435
per diem FTE	1.98

Part 2

RA

shifts/day	3
shifts/wk	21
days/yr	365
shifts/yr	1095
shifts by staff	660
per diem shifts	435
per diem FTE	1.98

Case Manager

shifts/day	1.5
shifts/wk	10.5
days/yr	365
shifts/yr	547.5
shifts by staff	440
per diem shifts	107.5
per diem FTE	0.49

NP

shifts/day	0.4
shifts/wk	2.8
days/yr	365
shifts/yr	146
shifts by staff	0
per diem shifts	146
per diem FTE	0.66

SAMPLE 17-20 BED TRANSITIONAL HOUSING BUDGET
Program and Administration Budget

a. SHP Program	c. Grant Term* (Check only one box)
b. Component Types (Check only one box)	1 Year 2 Years 3 Years
TH PH SSO HMIS	

d. Proposed SHP Activities	e. SHP Dollars Request	f. Cash Match	g. Totals (Col. d + Col. e)
1. Acquisition			$-
2. Rehabilitation			$-
3. New Construction			$-
4. Subtotal (Lines 1 through 3)	$-	$-	$-
5. Real Property Leasing From Leasing Budget Chart	$83,319.00		$83,319.00-
6. Supportive Services From Supportive Services Budget Chart	$38,906.00.	$9,727.00.	$48,633.00
7. Operations From Operating Budget Chart	$31,946.00	$10,649.00	$42,595.00
8. HMIS From HMIS Budget Chart			$-
9. SHP Request (Subtotal lines 4 through 8)	$154,171.00		
10. Administrative Costs (Up to 3% of line 9)	$4625.13	**Total Cash Match**	**Total Budget (Total SHP Request + Total Cash Match)**
11. Total SHP Request (Total lines 9 and 10)	$158,796.13	$20,376.00	$179,172.13